

American Academy of Acupuncture and Oriental Medicine
Multiple Sclerosis Clinic

Patient Enrollment Form

1) Name: _____ 2) Date: _____

3) Date of birth: _____ 4) Sex: M F 5) Marital status: single in relationship
married divorced widow

6) Place of birth and childhood _____

7) Age at MS diagnosis: _____ 8) Approx. time between onset of symptoms and MS diagnosis _____

9) Studies suggest that the onset of MS symptoms often coincides with a stressful time in a person's life. From the list below, please check any you experienced during the onset of your MS symptoms.

- Loss of family member or close friend
- Serious illness of a family member or close friend
- Divorce or end of a relationship
- Difficult pregnancy or care of a newborn
- Loss of employment or income
- Loss of residence or housing
- Personal trauma or serious injury
- Trauma or serious injury to a family member or close friend
- Other _____
- None

10) Studies suggest a link between the Epstein Bar or Herpes Simplex virus and MS. Were you infected with the Epstein Barr or Herpes Simplex virus any time prior to onset of MS symptoms? yes no don't know

11) Primary symptoms that led to an MS diagnosis: _____

12) List other family members diagnosed with MS: _____

13) Type of MS: acute subacute chronic

14) Disease course:
Primary Progressive Relapsing Remitting Remission
Secondary Progressive Progressive Relapsing

15) Approx. number of relapses per year: _____

16) Inducing factors of relapses:

<input type="checkbox"/> cold	<input type="checkbox"/> surgery
<input type="checkbox"/> pregnancy	<input type="checkbox"/> depression
<input type="checkbox"/> childbirth	<input type="checkbox"/> repressed anger
<input type="checkbox"/> stress	<input type="checkbox"/> no known trigger
<input type="checkbox"/> fever	<input type="checkbox"/> other reason _____

17) **Level of mobility:**

- wheel chair bound
- always require the use of a walker
- occasionally require the use of a walker
- always requires the use of a cane
- occasionally require the use of a cane
- slower gait, but no assistance is needed
- no assistance needed

18) **Current chief complaint:** _____

19) **Other symptoms, circle all that apply:**

- | | | | |
|-------------------|---------------|--------------------------|------------------|
| depression | poor appetite | susceptible to illnesses | nystagmus |
| irritability | diarrhea | dizziness | bulbar paralysis |
| insomnia | constipation | tremors | hyperreflexia |
| cognitive decline | night sweats | fever | optic neuritis |

20) **Prescription medications:** _____

21) **OTC medications:** _____

22) **Nutritional and herbal supplements:** _____

23) **Have you had your vitamin D level checked?** yes no
If yes, when? _____ What was your serum Vitamin D level at that time? _____

24) **How often do you see your neurologist?** _____

25) **Is this your first experience with acupuncture and Oriental Medicine?** yes no
If no, where else have you received treatment? _____

26) **Other therapies to manage MS symptoms:**

Have tried in the past Currently using

- | | | |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | chiropractic |
| <input type="checkbox"/> | <input type="checkbox"/> | massage |
| <input type="checkbox"/> | <input type="checkbox"/> | Healing Touch |
| <input type="checkbox"/> | <input type="checkbox"/> | western herbs |
| <input type="checkbox"/> | <input type="checkbox"/> | nutrition/special diet |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

27) **How did you hear about the AAAOM MS Clinic?** _____

AAAOM Multiple Sclerosis Clinic is compiling data for an MS study. Your signature below gives AAAOM consent to include your data for statistical purposes only. Your name and personal information will not be used or shared.

Signature

Date